



APPLICATION/REQUEST FOR SPECIAL ACCOMMODATIONS

ACKNOWLEDGEMENT OF RECEIPT OF MATERIALS

I hereby acknowledge that I received the Application/Request for Special Accommodations materials from the Antonelli Institute Designated Section 504 Coordinator.

Student Signature: _____

Name (Please print): _____

Date: _____



PROCESS TO REQUEST/APPLY FOR SPECIAL ACCOMMODATIONS

Purpose: The Designated Section 504 Coordinator and Antonelli Institute Accommodations Committee (AIAC) will use this application for Special Accommodations to determine the following:

1. Whether a student is a qualified disabled individual under US federal law; and
2. Whether the accommodation a student is requesting is reasonable.

Consideration of all requests will be made under applicable laws relating to the Americans with Disabilities Act.

Part I: Please completed Part I and include all supporting documentation.

(**Note:** A diagnostic exam or evaluation that assesses and indicates a student's level of disability must have been performed within the last three years to be used as supporting documentation.)

Part II: Your health practitioner or other appropriate professional completes Part II, which is to be signed and dated where indicated.

Submission of the forms: Both Parts I and II of this application must be fully completed and then submitted to the Designated Section 504 Coordinator before a decision on any accommodations requested can be considered. Incomplete forms will not be considered and may not be returned to the applicant. Please see the Designated Section 504 Coordinator for application and deadline information.

Antonelli Institute's Response to Request for Special Accommodations: The Designated Section 504 Coordinator and the AIAC will review both parts of the application and make a decision no later than three weeks after the student submits the fully completed request. The decision made by the Designated Section 504 Coordinator and the AIAC is final and the student may not submit another Request for Special Accommodation while in school.



APPLICATION/REQUEST FOR SPECIAL ACCOMMODATIONS
Part I (To be completed by the student)

Last Name/First Name/MI:

Complete Address:

Daytime Phone Number:

Evening Phone Number:

Major life activity impaired by disabling condition:

Accommodation(s) requested by applicant:

Names of Relevant Physicians or Other Health Care Practitioners:

Practitioner Name #1:

Office Address:

City/State/Zip:

Length of time as patient:

Practitioner Name #2:

Office Address:

City/State/Zip:

Length of time as patient:

Date Packet Returned: _____



RELEASE

I authorize each health care practitioner above to release to the Designated Section 504 Coordinator of Antonelli Institute information which will:

1. Verify the current functional limitations imposed by my disability which affect my ability to perform under standard educational conditions; and
2. Describe the nature of the educational accommodations being proposed and the rationale for those accommodations.

I further understand that I may be asked to provide additional information about my functional limitation(s) and the requested accommodations and agree to cooperate with reasonable requests for such additional information.

I understand and agree that the information obtained by this authorization will be used solely for the purpose of determining my eligibility for reasonable accommodations in regard to an Antonelli Institute educational program and the nature and extent of the accommodations which are reasonably necessary by reason of my disability. The information obtained by this authorization will not be released or disclosed to any person or organization except the AIAC, referenced parties, and any other governmental agency that may be involved in acting upon my request for reasonable accommodations in connection with the educational program.

I agree that this authorization shall be valid until canceled or revoked in writing by me. Under penalties of perjury, I declare that the foregoing statements and those in any required accompanying documents or statements are true. I understand that false information may be cause of denial or loss of accommodation. I hereby certify that I personally completed this application and that I may be asked to verify the above information at any time.

Student Signature: _____

Date: _____

Name (Please print): _____

Witness Signature: _____

Name (Please print): _____



APPLICATION/REQUEST FOR SPECIAL ACCOMMODATIONS
Part II-Practitioner's Statement

Each health care practitioner providing services to the patient should complete one copy of this two-page form and return it to Director of Education/Section 504 Coordinator, Antonelli Institute, 300 Montgomery Avenue, Erdenheim, PA 19038. (Please include all supporting documentation and use additional sheets as necessary.)

Practitioner Last Name/First Name/MI:

Office Address:

City/State/Zip:

Telephone Number:

Patient's Name:

Patient's Address:

City/State/Zip:

Patient's SSN#:

Date patient first seen:

Date patient last seen:

1. Diagnosis and description of disabling condition. (Please provide any other necessary information including tests administered to determine condition. **(NOTE:** A diagnostic exam or evaluation which assesses and indicates a student's level of disability must be performed within the last three years to be used and included as supporting documentation.)

2. Date of onset:



3. Major life activity limited by disabling condition:

4. Previous accommodations granted and when:

5. Accommodation(s) requested in this situation:

I hereby certify that the above information is true and is released pursuant to authorization by my patient.

Signature of Health Care Practitioner _____

Professional Status _____

Physician, Psychologist, etc. _____

License Number (if applicable) _____

Date _____



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